

# HEALTH AND HOUSING: ALTRUISTIC MEDICALIZATION OF AMERICA'S AFFORDABILITY CRISIS

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## I INTRODUCTION

This article argues in favor of responding to the lack of affordable housing in America as a public health crisis. The “medicalization”<sup>1</sup> frame adopted here responds to epidemiological evidence of the nexus between health and housing, invites collaborative and integrated solutions to improve health outcomes, and points to innovative financing streams to pay for policy recommendations. Harkening to the theme of this conference, the article is organized into three parts. Part II lays groundwork for the conclusion that contemporary housing policy should reflect historic notions of altruism in order to efficiently and effectively lower the public health costs imposed by a widespread lack of affordable housing. Part III identifies defects that make market solutions as poor a substitute for public health interventions today, as they were during nineteenth century America, when national housing policy began. The focus of this discussion points to the impact that housing affordability has on population health outcomes. Part IV identifies the communities that suffer when the public health burdens imposed by markets that lack affordable housing. This part advances the view that housing policy informed by a population health perspective could improve health outcomes not only in low-income communities, but also in the working-class and middle-income communities. The article concludes with a summary of the benefits and limitations of viewing housing affordability crises through a public health lens.

## II HEALTH AND HOUSING AFFORDABILITY—ALTRUISM

Contemporary commentators across a wide political spectrum seem to regard

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1. See *infra* Part II (explaining this article's use of “medicalization” to refer to the direct and indirect impact housing conditions have on health outcomes).

the trend toward “medicalization” with suspicion. On one hand, the term is associated with resurrecting the sixteenth century notions of the “unworthy poor,” who without medical pathology to explain their need, merited no public support or intervention.<sup>2</sup> Alternatively, feminist scholars debate the difference between “good”<sup>3</sup> and “bad”<sup>4</sup> medicalization as it affects social control over natural occurrences such as childbirth. And in still another critique, neoliberalist policy argues that medicalization constructs individualized solutions to structural problems, so that admonitions to cease smoking, exercise more, and drink less crowd out attention to social determinants of poor health.<sup>5</sup> Thomas Szasz once famously said that “medicalization is neither medicine nor science; it is a semantic-social strategy that benefits some persons and harms others.”<sup>6</sup> In contrast to these normative views, public health scholars regard “medicalization” as a scientific approach to promote and protect population health. For example, Thomas Frieden applied traditional public health tools to the HIV epidemic and thereby represented medicalization of a social debate in order to reduce the human and economic costs of a disease that continues to kill thousands.<sup>7</sup> This article offers support for a public health approach to a social crisis—the scarcity of affordable housing—in order to take advantage of a pragmatic opportunity where medicalization does no more (and no less) than describe one aspect of a serious and multifaceted problem to add much needed policy levers that might otherwise have been overlooked.

As used here, the term medicalization simply acknowledges the direct and indirect impact housing conditions have on population health outcomes. This perspective offers a broader and more integrated view of potential policy interventions by removing the silos that view social aspects of life outside the jurisdiction of medicine. It aligns with scientific evidence of direct and indirect impacts that social risks have on population health and makes evidence-based policy-making possible. This is particularly important to financing decisions. However, the core assertion in this article is that medicalization of housing policy not only provides an important framework for understanding a contemporary social problem, but also aligns with historical views of society’s role and relationship to people who are not wealthy. The equitable access to health and

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2. Helena Hansen et al., *Pathologizing Poverty: New Forms of Diagnosis, Disability, and Structural Stigma Under Welfare Reform*, 103 SOC. SCI. & MED. 76, 82 (2014).

3. See generally Erik Parens, *On Good and Bad Forms of Medicalization*, 27 BIOETHICS 28 (2013) (explaining that bioethics should avoid the simplifying assumption that medicalization is uniformly good or bad).

4. See generally Laura Purdy, *Medicalization, Medical Necessity, and Feminist Medicine*, 15 BIOETHICS 2248 (2001) (cautioning against rejection of a medicalization framework).

5. Antonio Marturo, *Medicalization: Current Concept and Future Directions in a Bionic Society*, 10 MENS SANA MONOGRAPHS 122, 128 (2011).

6. Thomas Szasz, *The Medicalization of Everyday Life*, THE THERAPEUTIC STATE 18, 19 (2007), <https://fee.org/articles/the-medicalization-of-everyday-life/> [<https://perma.cc/2VDM-2DYV>].

7. See generally Thomas R. Frieden et al., *Applying Public Health Principles to the HIV Epidemic*, 353 NEW ENG. J. MED. 2397 (2005).

well-being for all members of society—including those who are disadvantaged economically or otherwise — is a collective concern for a community that wishes to maintain a peaceful and democratic social order. A few examples from the historical record are illustrative.

#### A. An Historical View

Societal concern for the nearness and consistency with which housing is related to good health has been a feature of American history and policy since the mid-nineteenth century. Historically, there is evidence that the role of the state was to concern itself with the well-being of the less fortunate, in an expression of communal altruism. This was even more the case for care professionals, who assumed the responsibility to notice, describe, and intervene to prevent the health impacts of poor housing conditions.

In 1847, the New York Association for Improving the Condition of the Poor (AICP) reported on housing conditions in the city's urban tenements, explaining that the poor who lived there “suffer from sickness and premature mortality; their ability for self-maintenance is thereby destroyed; social habits and morals are debased, and a vast amount of wretchedness, pauperism and crime is produced.”<sup>8</sup>

In 1849, a committee of cholera investigators declared Half Moon Place in Boston “a perfect hive of human beings without comforts and mostly without necessities, packed ‘like brutes . . . .’”<sup>9</sup> While the investigators' language must certainly be read to reveal nativist biases, the report also evinces a societal obligation to create and maintain healthy living conditions for even the newly arrived and destitute. The Boston Internal Health Department, in its *1850 Report on the Cholera in Boston*, cited the crowded and inadequate housing conditions as a source of disease in the city that compelled the Commissioners' urgent intervention:

We would now refer to another subject which, in our view, also demands the attention and action of this Board. We allude to the very wretched, dirty and unhealthy condition of a great number of the dwelling houses, occupied by the Irish population in Batterymarch, Broad, Warf, Wells, Bread, Oliver, Hamilton, Atkinson, Curve, Brighton, Cove, Ann, and other streets . . . .<sup>10</sup>

As the cholera epidemic ravaged Boston's immigrant population, accounting in 1849 for over 500 of the reported 611 deaths in the city that year,<sup>11</sup> public health officials identified the physical state of the housing stock as a key contributor to

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8. N.Y. ASS'N FOR IMPROVING THE CONDITION OF THE POOR, FOURTH ANNUAL REPORT 23 (1847).

9. BOSTON COMM. ON INTERNAL HEALTH, REPORT OF THE COMMITTEE OF INTERNAL HEALTH ON THE ASIATIC CHOLERA, TOGETHER WITH A REPORT OF THE CITY PHYSICIAN ON THE CHOLERA HOSPITAL 13–14 (1849) [hereinafter REPORT ON THE CHOLERA IN BOSTON].

10. *Id.* at 12.

11. *Irish Immigrants and the 1849 Cholera Epidemic*, GLOBAL BOSTON (Dec. 31, 1849), <https://globalboston.bc.edu/index.php/cholera-report/> [https://perma.cc/H4A4-VFTA].

the epidemic:

The houses above alluded to are also insufficiently provided with the necessary in and out of door conveniences, which are required in every dwelling place. The great mass of them . . . have but one sink, opening into a contracted and ill constructed drain, or, as is frequently the case, into a passage way or street and but one privy, usually a mass of pollution, for all the inhabitants, sometimes amounting to a hundred. Some of them have neither drain nor privy; and the tenants are obliged to supply their necessities as best they can. Many of them were originally designed warehouses, and have been converted to their present uses as economically as possible; whilst others, which were once well fitted for the accommodation of a single family, have become wholly inadequate to meet the wants of the large numbers that now crowd into them . . .<sup>12</sup>

Notably, the nexus between the Boston Cholera outbreak, poor housing conditions, and the cost of housing was not overlooked. The direct relationship between housing affordability and the conditions most offensive to public health was not lost on the City Commissioners. The poor lived in unhealthy conditions because that was what they could afford. According to Jacob Riis' famous 1890 account, there was an positive and linear relationship between housing affordability and quality, vividly recounted in his depiction of the squalor that obtained in New York's twenty-five, ten, and "seven-cent lodging" houses.<sup>13</sup> "The rent for each room ranges from one dollar to one dollar and a half; and is generally collected by a man who hires the whole building, or several buildings, and enforces prompt payment under the threat always rigidly executed, of immediate ejection."<sup>14</sup>

The pattern of directly relating the cost and quality of housing conditions is replicated all over the country. Housing conditions' relationship to housing affordability deeply concerned the Philadelphia County Medical Society, whose 1855 *Account of the Prevalent Disease in the Consolidated City During the Year* named "dwellings and social condition of the poor" among the "causes which modify the health of the county":

Among other sanitary evils entailed upon our city, which contribute to increase its unhealthiness and swell its bills of mortality may be included the habitations and the social condition, of a portion of the laboring classes and the vagrant poor. It is here that we find a large amount of preventable disease, the certain result of overcrowded, filthy, damp, unventilated tenements, with their half-famished occupants daguerreotyped in physical and moral uncleanness.<sup>15</sup>

These physicians called for the city's officials to address housing conditions to achieve many social goals, "but, above all, a sensible abatement of disease in our Blockley Hospital wards, while our bills of mortality would show a falling off in untimely and preventable deaths."<sup>16</sup> In 1832, in an apparent refutation of notions that cholera had killed the poor because they were morally weak, the

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12. REPORT ON THE CHOLERA IN BOSTON, *supra* note 9, at 13.

13. JACOB A. RIIS, HOW THE OTHER HALF LIVES 86 (Dover Publications 1971) (1890).

14. REPORT ON THE CHOLERA IN BOSTON, *supra* note 9, at 14.

15. WILSON JEWELL, SANITARY, METEOROLOGICAL AND MORTUARY REPORT OF THE PHILADELPHIA COUNTY MEDICAL SOCIETY FOR 1855, at 18 (1856).

16. *Id.* at 19.

New York Board of Health Hospital Physicians summed up the problem this way: “The real suffering of the poor is easily explained. They lived in the worst houses in the most crowded portions of the city and could not afford to flee when threatened by the epidemic.”<sup>17</sup> The history of this long-standing association between public health and housing conditions in America has been recounted elsewhere.<sup>18</sup> The purpose of referencing that association here is to place the nexus into chronological context.

Beyond recognizing the close connection between housing and health, the historical record is also noteworthy for the evidence of altruism that that appears to accompany these reports of unhealthy housing conditions. Altruism, according to the Oxford English Dictionary, is a devotion to the welfare of others, regard for others, as a principle of action; opposed to egoism or selfishness.<sup>19</sup> The American Psychological Association suggests altruism may be a uniquely human behavior that is characterized by actions that benefit another at a cost to oneself.<sup>20</sup> Eminent sociological theorists from August Comte, to Emile Durkheim, Max Weber, and Talcott Parsons all viewed altruism as fundamental to understanding human behavior, interaction and cooperation.<sup>21</sup> Certainly, the language nineteenth century health commissioners used to describe conditions—“wretched” and “wholly inadequate,” for example<sup>22</sup>—evinces a distress and deep concern consistent with this understanding of altruism. Moreover, these early reports also convey a sense of urgency about unsanitary housing conditions that led nineteenth century physicians to “demand” attention to avoid “untimely and preventable” deaths.<sup>23</sup> The deaths were not counted by the wealthy professionals, or even by the government bureaucrats tasked with surveillance because of any direct effect the mortality rate had on them or their families or even their immediate communities. Instead, their concern was over health and living conditions among others distinctly unlike themselves—immigrants, vagrants, and the poor—and therefore qualified as altruism.<sup>24</sup> While the nature of altruism that motivated nineteenth century concerns for the poor may have changed over time,

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17. Mary Shaw, *Housing and Public Health*, 25 ANN. REV. PUB. HEALTH 397, 400 (2004) (quoting NYC BOARD OF HEALTH, REPORT OF HOSPITAL PHYSICIANS 65 (1832)).

18. See, e.g., James Krieger & Donna Higgins, *Housing and Health: Time Again for Public Health Action*, 92 AM. J. PUB. HEALTH 758 (2002) (urging public health departments to use multiple strategies to improve housing in the tradition of nineteenth century health officials).

19. *Altruism*, OXFORD ENGLISH DICTIONARY (2d ed. 1989).

20. *Altruism May be Universally and Uniquely Human*, AM. PSYCHOL. ASS'N (June 25, 2015), <http://www.apa.org/pubs/highlights/peeps/issue-48.aspx>.

21. Robert Wuthnow, *Altruism and Sociological Theory*, 67 SOC. SERV. REV. 344, 344–45 (1993).

22. REPORT ON THE CHOLERA IN BOSTON, *supra* note 9, at 12.

23. JEWELL, *supra* note 15, at 19.

24. In contrast, the nineteenth century also played host to the theory of Social Darwinism that held the poor who had “propensities for idleness, criminality, sexual misbehavior, and alcoholism [that] were passed along from generation to generation by heredity” deserved no assistance “lest their improvidence be rewarded.” Peter Hall, *Social Darwinism and the Poor*, SOCIAL WELFARE HISTORY PROJECT, <http://socialwelfare.library.vcu.edu/issues/social-darwinism-poor/> [https://perma.cc/5572-9PBG] (last visited Apr. 15, 2018).

the fundamental link between poor housing conditions and poor health remains constant.

### B. Contemporary Evidence

Today, social and clinical scientists estimate that only 10% of health outcomes are determined by health care.<sup>25</sup> In fact, social determinants have far greater influence on health disparities than medical care alone. It is estimated that differences in social and environmental factors account for approximately 20% of health outcomes.<sup>26</sup> Another 40% of health outcomes are related to health behaviors which occur within a social context and are therefore susceptible to environmental influences.<sup>27</sup> Therefore, social determinants play a much larger role in determining health outcomes than genetics or health care. Housing, in particular, has been shown in a number of epidemiological studies to be an important determinant of population health.

The strongest evidence in this body of studies shows that the physical quality of housing conditions directly and indirectly influences the health outcomes that they experience. Poor ventilation, lighting, and crowding have been associated with the spread of communicable diseases such as tuberculosis and cholera. Roaches and inadequate heating are correlated with increased incidence of asthma.<sup>28</sup> Indeed, the third National Health and Nutrition Examination Survey (NHANES) estimated that 40% of childhood asthma is related to a child's home environment.<sup>29</sup> Sub-standard housing conditions such as dampness, inadequate ventilation, mold, and lack of heat causally relate to chronic disease.<sup>30</sup> Deteriorated home environments have been associated with respiratory disease, neurological disorders, psychological and behavioral dysfunction.<sup>31</sup> The presence of lead in paint, plumbing, and water has been well documented as a condition that produces long term, adverse impacts on health.<sup>32</sup> Researchers have connected the incidence and prevalence of infectious disease with insufficient

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25. Steven A. Schroeder, *We Can Do Better – Improving the Health of the American People*, 357 NEW ENG. J. MED. 1221, 1225 (2007).

26. *Id.*

27. *Id.*

28. Rachel Meltzer & Alex Schwartz, *Housing Affordability and Health: Evidence from New York City*, 26 HOUSING POL'Y DEBATE 80, 82 (2015).

29. Megan Sandel & Matthew Desmond, *Investing in Housing for Health Improves Both Mission and Margin*, 318 J. AM. MED. ASS'N 2291, 2291 (2017).

30. See Matthew Desmond & Monica Bell, *Housing, Poverty, and the Law*, 11 ANN. REV. L. & SOC. SCI. 15, 20 (2015) (linking “poor housing conditions to a wide array of health problems, from asthma, lead poisoning, and respiratory complications to developmental delays, heart disease, and neurological disorders”).

31. Samiya Bashir, *Home Is Where the Harm Is: Inadequate Housing as a Public Health Crisis*, 92 AM. J. PUB. HEALTH 733, 733 (2002).

32. *Lead*, NAT'L CTR. FOR HEALTHY HOUSING, <http://www.nchh.org/What-We-Do/Health-Hazards—Prevention—and-Solutions/Lead.aspx> [<https://perma.cc/B9YS-5BKR>] (last visited Apr. 15, 2018).

water supply, leaky plumbing and insufficient sanitation.<sup>33</sup> Annually, many people are injured in homes that have structural and design defects such as faulty furnaces that emit carbon monoxide, unstable stairwells associated with falls, and electrical defects associated with burns and fires.<sup>34</sup>

In addition to indoor housing conditions, researchers have linked outdoor neighborhood conditions to health outcomes, suggesting that housing is an important determinant of health at the community level.<sup>35</sup> Neighborhood risk factors such as poor air quality due to proximity to land-fills, power plants, or interstate highways have been shown to adversely impact the health of whole neighborhoods of children and their families.<sup>36</sup> Moreover, housing in low-income neighborhoods can be less healthy because of the built-environment that surrounds. Housing that lacks walkable proximity to green and recreational spaces, healthy food outlets, or even high-quality medical care imposes an added burden on community health. Researchers have shown an association between the built-environment and the level of physical activity, the incidence of obesity, depression, and even alcohol abuse.<sup>37</sup> Additionally, social scientists point to a number of differences among neighborhoods that can have a significant health impact. Three examples include: access to fresh, healthy food options, as compared to fast and convenience food outlets;<sup>38</sup> access to built-environments suitable for exercise and recreation as compared to crowded and unsafe neighborhood conditions;<sup>39</sup> and open and green spaces compared to the disproportionate presence of unhealthy tobacco, and alcohol marketing.<sup>40</sup>

Residential segregation—both economic, and racial—has also been linked to adverse community health outcomes. In their article, Williams and Collins explain that racial residential segregation is a “fundamental cause” of inequitable health outcomes that affect minority populations.<sup>41</sup> They argue that segregation is a structural cornerstone of black-white health disparities because they affect an entire community’s exposure to jobs, education, poverty, crime, food,

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33. Krieger & Higgins, *supra* note 18, at 758.

34. *Id.*

35. See Ernie Hood, *Dwelling Disparities: How Poor Housing Leads to Poor Health*, 113 ENVTL. HEALTH PERSP. 310, 312 (2005) (describing how various aspects of the built environment can affect health outcomes).

36. *Id.*

37. Arlene Renalds et al., *A Systematic Review of Built Environment and Health*, 33 FAM. COMMUN. HEALTH 68, 76 (2010).

38. Heather D’Angelo et al., *Access to Food Source and Food Source Use are Associated with Healthy and Unhealthy Food Purchasing Behaviors Among Low-Income African-American Adults in Baltimore City*, 14 PUB. HEALTH NUTRITION 1632, 1637 (2011).

39. See James F. Sallis et al., *Neighborhood Built Environment and Income: Examining Multiple Health Outcomes*, 68 SOC. SCI. MED. 1285, 1291 (2009) (explaining how walkable neighborhoods can affect both physical and mental health).

40. See, e.g., Thomas A. LaVeist & John M. Wallace, *Health Risk and Inequitable Distribution of Liquor Stores in African American Neighborhoods*, 51 SOC. SCI. MED. 613, 613–17 (2000).

41. David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUB. HEALTH REP. 404, 404 (2001).

transportation, built-environment, and pollution.<sup>42</sup> Moreover, they identify segregation as a key determinant in disparate socio-economic outcomes and mobility. The inferior resources that low-income neighborhoods enjoy, when compared to wealthier ones, result in higher incidence and prevalence of related infirmity. For example, childhood asthma is closely associated with whether families occupy housing in segregated or integrated neighborhoods.<sup>43</sup> Additionally, several studies document the association between segregated neighborhood conditions and mental health. A study of adolescent mental health showed that both subjective (attractiveness, desirability) and objective neighborhood conditions (crime, blight) have an impact on adolescents' mental health and health behavior.<sup>44</sup> Others have identified the harm segregation visits upon social networks and social capital, as well as poor pregnancy outcomes.<sup>45</sup> The evidence is not uniform, but researchers have also found associations between residential segregation and the risks associated with diabetes,<sup>46</sup> hypertension,<sup>47</sup> and heart disease and stroke.<sup>48</sup>

In his book *Stuck in Place*, Paul Sharkey documents the impact that concentrated neighborhood poverty has on African American and Latino families and children who disproportionately live in neighborhoods where the concentration of poverty is higher, and access to health resources is lower, even when these minority families are not low-income families themselves.<sup>49</sup> The feeling of being relegated to inferior housing and neighborhoods along with the implied second class status has been linked with poor self-reported health, depression, anxiety, stress and poor health behaviors.

Unlike the relationship between physical housing, neighborhood conditions, and health, which has been studied extensively, the relationship between the *cost*

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42. *Id.*

43. Diane Alexander & Janet Currie, *Is it Who You Are or Where You Live? Residential Segregation and Racial Gaps in Childhood Asthma*, 55 HEALTH ECON. 186, 187 (2017).

44. Carol S. Aneshensel & Clea A. Sucoff, *The Neighborhood Context of Adolescent Mental Health*, 37 J. HEALTH & SOC. BEHAV. 293, 294 (1996).

45. Michael R. Kramer & Carol R. Hogue, *Is Segregation Bad for Your Health?*, 31 EPIDEMIOLOGIC REV. 178, 183 (2009).

46. Kiarri N. Kershaw & Ashley E. Pender, *Racial/Ethnic Residential Segregation, Obesity, and Diabetes Mellitus*, 16 CURRENT DIABETES REP. 107, 107 (2016). *But see* Diana S. Grigsby-Toussaint et al., *Residential Segregation and Diabetes Risk among Latinos*, 25 ETHNICITY & DISEASE 451, 451 (2015) (observing that no relationship between segregation and diabetes risk existed). *See also* Antwan Jones et al., *Black-White Residential Segregation and Diabetes Status: Results from the Behavioral Risk Factor Surveillance System*, 3 OPEN J. PREVENTIVE MED. 165, 169 (2013) (finding no association between diabetes prevalence among blacks and segregation).

47. Kiarri N. Kershaw et al., *Metropolitan-Level Racial Residential Segregation and Black-White Disparities in Hypertension*, 174 AM. J. EPIDEMIOLOGY 537, 537 (2011).

48. Sophia Greer et al., *Metropolitan Racial Residential Segregation and Cardiovascular Mortality: Exploring Pathways*, 91 J. URB. HEALTH 499, 499 (2013).

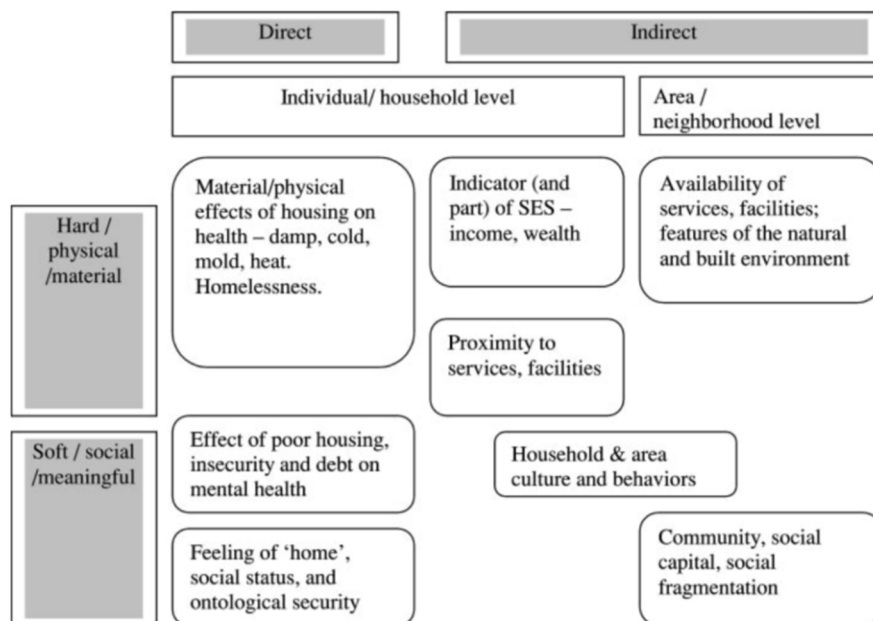
49. *See generally* PAUL SHARKEY, *STUCK IN PLACE* (2013). *See also* Jens Ludwig et al., *Neighborhood Effects on the Long-Term Well-Being of Low Income Adults*, 337 SCI. MAG. 1505, 1509 (2012) (finding that moving from high-poverty to lower-poverty neighborhood leads to long-term improvement in physical and mental health).



of housing and health is a relatively new research area. Samiya Bashir described the shortage of affordable housing as a “public health crisis” in 2002, reporting that “across the country, more than five million families—over four million children—are living in substandard housing that despite its wretched state, they can barely afford.”<sup>50</sup> The association among housing affordability, conditions, and health outcomes is not well understood. Researchers have theorized and confirmed associations between health and housing conditions and housing stability on an individual, household, and neighborhood level, but have thus far not incorporated a full understanding of the relationship between housing affordability and population health outcomes.

The conceptual diagram in Figure 1 is often cited to describe the direct and indirect ways in which housing can affect health. It is highly regarded because it incorporates both direct and indirect links between housing and health, on an individual and collective neighborhood level. Moreover, this diagram explains that housing impacts can be the result of housing’s “hard,” physical features, or because of “soft” effects that are less easily measured. Yet, notably, housing affordability is missing. According to this diagram, one’s relationship to the financial markets in which housing is bought, sold, and leased barely enters the health picture.

Figure 1: Shaw’s Framework for the Direct and Indirect Ways Housing Can Affect Health<sup>51</sup>



50. Bashir, *supra* note 31, at 734.

51. Shaw, *supra* note 17, at 398.

In this conceptual framework, income available to purchase housing may signal wealth, or may comprise wealth, but is not clearly connected to health outcomes in any way. This framework does admit that debt associated with housing insecurity may have a “soft” impact on mental health. However, more recent research demonstrates that the health impacts a lack of affordable housing may have on population health are far more significant than this important but incomplete framework shows.<sup>52</sup>

Therefore, the next part of this article explores a more comprehensive understanding of the relationship between housing affordability and health. It concludes that improving housing markets will improve the health in America’s most vulnerable communities, and the health of middle-income families. This exploration also suggests that the magnitude of the housing affordability crisis has not been subjected to the nineteenth century notions of altruism that prompted collective, altruistic concern for the health of poorly housed communities during the Industrial Revolution. A medicalized view of housing and health could re-introduce altruism as a motivating factor to help address the growing number of communities where housing is unaffordable and therefore unhealthy for individuals, families, and households across the country. Most importantly, the medicalization of housing affordability advances the “public good” — an object of core collective concern since our nation’s inception.<sup>53</sup>

### III

#### THE AFFORDABILITY CRISIS—MARKETS MATTER FOR HEALTH

Since the “Great Recession” that lasted from approximately December 2007 to June 2009,<sup>54</sup> the United States’ recovery has been steady, with the economy entering its ninth year of expansion as of July 2017.<sup>55</sup> Housing markets in most but not all states have recovered as well. The Harvard Joint Center for Housing Studies reported in September 2017 that the housing market in the United States

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52. See, e.g., *Health in Housing: Exploring the Intersection Between Housing and Health Care*, ENTERPRISE COMMUNITY (Nov. 2015), <https://www.enterprisecommunity.org/download?fid=4489&nid=4243> [https://perma.cc/Z66P-GG3S]. See also Elizabeth J. Mueller et al., *Making the Case for Affordable Housing: Connecting Housing With Health and Education Outcomes*, 23 J. PLANNING LITERATURE 371 (2007).

53. See THE DECLARATION OF INDEPENDENCE paras. 1–2 (U.S. 1776) (consider, for example, the notions of collective action in the preamble: “When in the Course of human events it becomes necessary for one people to dissolve the political bands . . .” and the first listed injury assigned to the King of Great Britain was that “he has refused his assent to laws, the most wholesome and necessary for the *public good*”) (emphasis added).

54. See *Chart Book: The Legacy of the Great Recession*, CTR. ON BUDGET & POL’Y PRIORITIES (Jan. 26, 2018), <https://www.cbpp.org/research/economy/chart-book-the-legacy-of-the-great-recession> [https://perma.cc/C347-ADMN].

55. Steve Matthews & Catarina Saraiva, *These U.S. States Still Haven’t Fully Recovered from Recession*, BLOOMBERG (July 6, 2017), <https://www.bloomberg.com/news/articles/2017-07-06/these-u-s-states-still-haven-t-fully-recovered-from-recession> [https://perma.cc/F9U3-7U4P].

has largely returned to “normal” following the 2008 “Great Recession,” with increasing housing demand, home construction, and prices.<sup>56</sup> Yet, in a twist of irony, the general economic recovery has actually decreased housing affordability for two reasons. First, the recovery is marred by the fact that increasing home prices also means decreasing affordability for many Americans whose incomes have not kept pace with housing price increases. The Pew Charitable Trust reports that between 2001 and 2014, rental prices rose by 7% while real wages fell by as much as 9% during the same period.<sup>57</sup> Second, to the extent that incomes have increased since the recession, they have done so unevenly, so that the inequity between high, middle, and low-income households has also increased.<sup>58</sup> Thus over the last ten years, housing has become increasingly less affordable for many more non-wealthy Americans. A variety of other factors also contribute to a lesser extent; for example, the amount of affordable housing that is being used for short-term rentals through programs like Airbnb can significantly reduce the available affordable housing for families.<sup>59</sup>

Every state and the District of Colombia has a shortage of affordable and available housing for the lowest-income populations.<sup>60</sup> The National Low-Income Housing Coalition estimates that the United States has only thirty-five affordable housing units available for every 100 renters with incomes at or below the Federal Poverty Level.<sup>61</sup> These shortages vary regionally. Western states such as Nevada, California, Arizona, Oregon and Colorado have between fifteen and twenty-seven affordable homes available for their poorest residents, while southern states like Alabama, West Virginia, Mississippi have more than fifty homes that are affordable and available for every 100 low-income renters. Middle-income families have more housing choices and can occupy housing that would otherwise be affordable for low income renters and home-buyers, and therefore the housing affordability crisis these families face varies from city to city. For example, an estimate prepared by *Governing* magazine researchers, represented in Figure 2 below, shows that middle-income families<sup>62</sup> who seek a

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56. THE STATE OF THE NATION’S HOUSING, J. CTR. FOR HOUSING STUD. AT HARVARD UNIVERSITY 1 (2017), [http://www.jchs.harvard.edu/research/state\\_nations\\_housing](http://www.jchs.harvard.edu/research/state_nations_housing) [https://perma.cc/JN99-93WT] [hereinafter HARVARD J. CTR. REP.].

57. Sarah Breitenbach, *States, Cities Tackle Housing Crisis for Low, Moderate Income Families*, PEW CHARITABLE TRUSTS (Jan. 29, 2016), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/01/29/states-cities-tackle-housing-crisis-for-low-moderate-income-families> [https://perma.cc/7Y2W-8TQD].

58. Chad Stone et al., *A Guide to Statistics on Historical Trends in Income Inequality*, CTR. ON BUDGET & PRIORITY POLICIES (Oct. 11, 2017), <https://www.cbpp.org/research/poverty-and-inequality/a-guide-to-statistics-on-historical-trends-in-income-inequality> [https://perma.cc/SH27-EG2Z].

59. See Breitenbach, *supra* note 57.

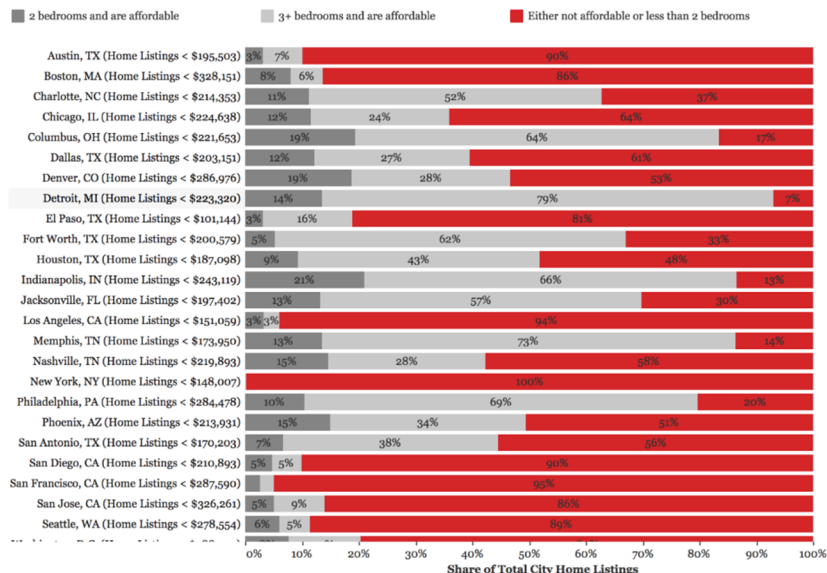
60. *The Gap – A Shortage of Affordable Homes*, NAT’L LOW-INCOME HOUSING COALITION 6 (Mar. 2017), [http://nlihc.org/sites/default/files/Gap-Report\\_2017.pdf](http://nlihc.org/sites/default/files/Gap-Report_2017.pdf) [https://perma.cc/EE7M-QLN4].

61. *Id.*

62. Middle-income families are defined as households earning 75% of the area median family income (AMI). *Family Housing Affordability in U.S. Cities*, GOVERNING THE STATES & LOCALITIES (Nov. 2015), <http://www.governing.com/gov-data/other/family-housing-affordability-in-cities->

two-bedroom home, face an affordability crisis in most of America's top twenty-five cities.<sup>63</sup> The chart shows that in Austin, Texas, for example, a family earning 75% of the AMI can afford only 3% of the two-bedroom houses listed in 2015, and 3% of the three-bedroom houses, but the remaining 90% of houses on the market were unaffordable.

Figure 2: Home Values in Top 25 American Cities, Affordable for Families Earning 75% of the Median Family Income, 2015<sup>64</sup>



SOURCE: Listings data provided by Trulia, current as of September 2015

As a result, the data reviewed in the next section describes the affordability crisis in practical terms as an increasing number of households are forced to pay a disproportionate share of their incomes on housing or accept sub-standard housing conditions that they can afford. This crisis challenges our national goal set in 1949 of “a decent home in a suitable living environment for every American family,”<sup>65</sup> and, thereby also threatens the health of millions of Americans.

### A. Affordability Defined

Since the nineteenth century, the concept of housing “affordability” has

report.html [https://perma.cc/KA26-7DMM].

63. *Id.*

64. *Id.*

65. Housing Act of 1949, 42 U.S.C. § 1460(d) (2012).

generally been measured by a ratio of housing expenditure to income.<sup>66</sup> This measure serves to assess the extent to which the costs associated with purchasing housing are within financial means on an individual or family level. Affordability refers to the portion of a household's total income that is required to pay rent or a mortgage. Affordability ratios can be used to compare different segments of the population and the respective burden that housing costs place on their overall budgets. The ratios can also describe a community's affordability trends—whether at the local, state, or national level. For example, the ratio of house prices to median household income in the United States during 2015 was just over 100, however in San Francisco and Los Angeles, the ratio exceeded 140, while in the St. Louis market the ratio did not reach the national average, demonstrating that housing affordability varies geographically.<sup>67</sup>

Aggregate affordability ratios describe the community's need for housing on a population level. Housing affordability describes community-wide housing need by calculating the proportion of the population spending more than 30% of income on housing. Over one third of American households are cost-burdened by this measure.<sup>68</sup> However, critics of the ratio claim this latter application is invalid because it fails to account for differences among household spending.<sup>69</sup> Whether measuring individual, household, or population level housing affordability, the underlying principle is that housing affordability ratios express the ability to purchase shelter by capturing the relationship between incomes and housing costs.

The general rule of thumb is that households should spend no more than 30% of their income on housing. A household spending more than 30% of its income on housing is considered “burdened” while households that spend more than 50% of their income on housing are considered “severely burdened.”<sup>70</sup> Nearly nineteen million households nationwide, therefore, are severely cost burdened because they paid more than half of their incomes for housing last year.<sup>71</sup> As shown in Figure 3, renters comprised eleven million of those households, and the remaining were homeowner households.

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66. While this percentage is generally the accepted measure of affordability, it is not the only measure. Many professional organizations (for example, the National Association of Realtors and the National Association of Home Builders), advocacy groups (for example, the National Low-Income Housing Coalition) and government entities (such as Freddie Mac) publish more specialized measures of affordability. See Caroline Nagel, *Affordable Housing Indices*, in THE ENCYCLOPEDIA OF HOUSING 12, 12–13 (2d ed. 1998).

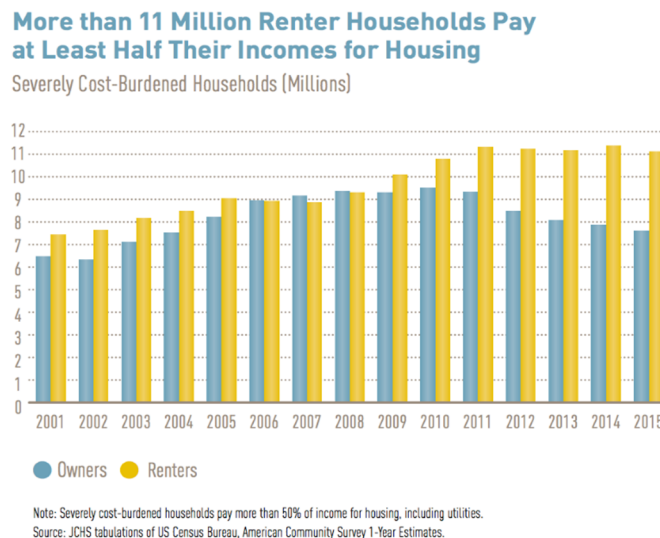
67. *American House Prices: Realty Check*, THE ECONOMIST (Aug. 24, 2016), <https://www.economist.com/blogs/graphicdetail/2016/08/daily-chart-20> [<https://perma.cc/BP53-NCDA>].

68. HARVARD J. CTR. REP., *supra* note 56, at 31.

69. J. David Hulchanski, *The Concept of Housing Affordability: Six Contemporary Uses of the Housing Expenditure-to-Income Ratio*, 10 HOUSING STUD. 471, 482–83 (1995).

70. Mary Schwartz & Ellen Wilson, *Who Can Afford To Live in a Home?: A Look at Data From the 2006 American Community Survey*, U.S. CENSUS BUREAU, at 1 (2006), <https://www.census.gov/housing/census/publications/who-can-afford.pdf> [<https://perma.cc/4KNC-5YLA>].

71. See HARVARD J. CTR. REP., *supra* note 56, at 5.

Figure 3<sup>72</sup>

The harsh take-away message from Figure 3 is in observing the trends over time. A markedly widening gap has opened between the number of homeowner households that are severely burdened, and the number of households that can only afford to rent housing. While the number of cost-burdened renters is generally increasing, the number of cost-burdened home-owners is going down. Desmond and Bell paint an even bleaker picture for some segments of the population, reporting that while median rents have increased nationwide over 70% since 2000, and utility costs have increased by over 50% during the same period, the majority of low-income families in America spend half their income on housing and nearly 25% of this same population spends over 70% of their income on rent. Moreover, the data belie a “housing affordability crisis,” in which an increasing number of non-poor, as well as poor households are forced to pay a disproportionate burden of their incomes on housing or accept substandard conditions that they can afford.

While one third of U.S. households are cost burdened, certain segments of the population are especially disadvantaged. Renters are more susceptible to affordability pressures than homeowners. Low and middle-income renters face the most serious affordability challenges; 83% of renters with incomes below \$15,000, and 77% of renters with incomes between \$15,000 and \$29,000 were cost-burdened in 2015.<sup>73</sup> However, in large, metropolitan areas where housing shortages are greatest, even middle-income renters face severe housing cost-

72. *Id.*

73. See HARVARD J. CTR. REP., *supra* note 56, at 31.

burdens.<sup>74</sup> High housing costs also disproportionately impact children, younger adults, older adults, black, Hispanic, and Asian homeowners and renters, and the disabled.<sup>75</sup>

Several market developments contribute to the affordability crisis. The first and most obvious contributor is the fact that housing prices have outpaced earnings in America. During the ten-year period from 1998 to 2008, Harvard's Joint Center for Housing reports that while the median renter's income decreased by 2.4%, median rent prices grew by 8%.<sup>76</sup> The sheer number of low-income families increased by 18% from 1998 to 2005<sup>77</sup>; the number of low-income working families rose from 10.2 million in 2010 to 10.4 million in 2011.<sup>78</sup> At the same time, the number of housing units that this group could afford decreased by 6%. This is due largely to the second factor contributing to the affordability crisis: the decrease in older housing stock in America. During the decade from 1997 to 2007, approximately one-third of all housing that was built before 1940, renting for \$400 per month or less, was torn down, converted to owner-occupancy, or shifted upwards to a higher rental price category.<sup>79</sup> A third factor contributing to the affordable housing shortage is the reduction in the availability of federally subsidized housing which have been either torn down, or converted by owners to non-subsidized housing. Finally, some argue that regulatory provisions such as minimum size requirements and large-lot zoning restrictions that apply to new construction have also contributed to the affordability crisis and its public health consequences.<sup>80</sup>

## B. How Housing Affordability Impacts Health

When housing becomes unaffordable, families make trade-offs. Three are possible: They could spend less on other family needs in order to afford housing; choose cheaper, lower quality homes in order to spend less of their budget on housing; or go without housing altogether. According to the U.S. Census Bureau and the United States Department of Housing and Urban Development, in 2011, 49.8 million households—that is 125 million Americans or 40% of the population—either lived in physically deficient housing, spent in excess of 30%

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74. *Id.* at 28–32 (noting that in metropolitan cities such as Los Angeles, New York, San Diego, and Washington, D.C., even modest earners face an affordability crisis as 70% of renters who earn between \$30,000 and \$45,000 annually, and 50% of those who earn between \$45,000 and \$75,000 annually spend more than 30% of their income on housing).

75. *Id.* at 31 (explaining that in 2015, 47% of African American households, 44% of Latino households, and 37% of Asian families were cost burdened, compared to 28% of white households).

76. Robert M. Buckley & Alex F. Schwartz, *Housing Policy in the U.S.: The Evolving Sub-national Role* 5 (Int'l Aff. New Sch., Working Paper 2011-06, 2011).

77. *Id.*

78. Brandon Roberts et al., *Low-Income Working Families: The Growing Economic Gap*, WORKING POOR FAM. PROJECT (2012–2013), [http://www.workingpoorfamilies.org/wp-content/uploads/2013/01/Winter-2012\\_2013-WFPF-Data-Brief.pdf](http://www.workingpoorfamilies.org/wp-content/uploads/2013/01/Winter-2012_2013-WFPF-Data-Brief.pdf) [<https://perma.cc/SDP6-BA8R>].

79. Buckley & Schwartz, *supra* note 76, at 6.

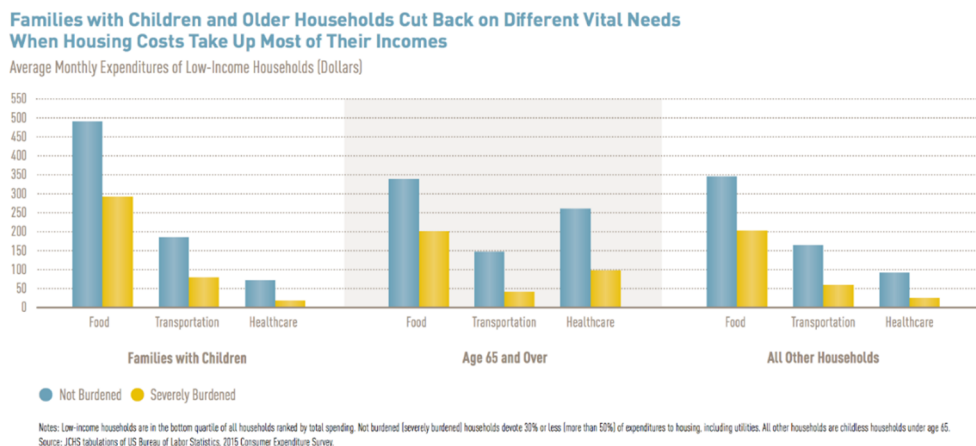
80. *Id.*

of their income, or were homeless.<sup>81</sup> Each of the three possible trade-offs can have an impact on health outcomes.

### 1. Unhealthy Spending Trade-Offs

Low- and middle-income households that spend a large share of their monthly budgets to secure housing tend to save by spending less on food and medical care. The health impacts result when these families skimp on items that have a direct, adverse impact on health. The most obvious category is food. When a family spends more than 50% of its budget on housing, the remaining 50% is stretched further and can result in decreased spending that directly impacts health. Figure 4 taken from the Harvard Joint Center on Housing Report, provides empirical evidence of this Hobbesian choice, which has been dubbed the “heat or eat” dilemma, and is all too familiar for families over-burdened by the cost of housing.<sup>82</sup>

Figure 4<sup>83</sup>



This graph raises several concerns. Notably, cost-burdened families with children compromise on food purchases. That means that children who are lucky enough to live in housing their families can afford eat more, and most likely better, food than families who live in unaffordable housing. Several researchers have shown that as a state’s average rent increases, the rate of food insecurity also increases, and this data shows that the impact is visited first and foremost on

81. ALEX F. SCHWARTZ, *HOUSING POLICY IN THE UNITED STATES* 1 (2d ed. 2015).

82. Deborah A. Frank & Joseph P. Kennedy III, *The Heat or Eat Dilemma*, THE BOS. GLOBE (Oct. 21, 2007), [http://archive.boston.com/news/globe/editorial\\_opinion/oped/articles/2007/10/21/the\\_heat\\_or\\_eat\\_dilemma/](http://archive.boston.com/news/globe/editorial_opinion/oped/articles/2007/10/21/the_heat_or_eat_dilemma/) [<https://perma.cc/ZG78-SMT4>].

83. HARVARD J. CTR. REP., *supra* note 56, at 34.



children.<sup>84</sup> Given the copious evidence of the link between nutrition and children's cognitive development, this health consequence of housing unaffordability is likely to last a lifetime. Second, this graph illustrates that elderly residents not only spend far less on food when they are cost-burdened, but also on health care when compared to those who are wealthier. Both of these trade-offs implicate the health outcomes for fragile, yet growing populations, that generate the most expensive health care bills of any demographic group in the nation.

Many studies show that adults and children living in housing that is beyond their means are less healthy. Adults living in unaffordable housing are more likely to self-report that their health is fair or poor compared to those living in affordable housing. Cost-burdened adults or adults facing foreclosure are less likely to fill prescriptions or adhere to health treatments.<sup>85</sup> Seniors are more likely to have depression and adolescents are more likely to have anxiety/aggression when access to affordable housing is limited.

Increases in housing costs have been associated positively with increased food insecurity among children.<sup>86</sup> Johns Hopkins researchers were able to identify specific areas of children's cognitive achievement affected by housing affordability.<sup>87</sup> They looked at reading comprehension and math ability for children who live in low and moderate-income households facing a large housing cost burden. They found that cost-burdened households compromise more than food, transportation, and medical care as seen above. Housing unaffordability is also associated with reduced family investments in educational enrichment for children, thus depressing their life chances from an early age. The effect of the burden is strongest on children's math ability, but also impacts reading skills. This research showed that low-income families, that have low housing cost-burdens because they have chosen to live in inferior housing, also spend less on their children's cognitive development. This research importantly highlights "a rarely acknowledged fact is that for low-income families, a low housing cost-burden warrants concern because of its likely association with living in a poor-quality housing unit and neighborhood."<sup>88</sup>

Families in search of affordable housing move more frequently, producing housing instability which is another documented determinant of poor health outcomes.<sup>89</sup> Frequent moves—often a symptom of housing unaffordability—are associated with higher rates of behavioral and mental health issues among

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84. Jason M. Fletcher et al., *Assessing the Effect of Changes in Housing Costs on Food Insecurity*, 15 J. CHILD. & POVERTY 79, 86 (2009).

85. Meltzer & Schwartz, *supra* note 28, at 83.

86. See Fletcher et al., *supra* note 84, at 86.

87. Sandra Newman & C. Scott Holupka, *Housing Affordability and Children's Cognitive Achievement*, 35 HEALTH AFFAIRS 2092, 2098 (2016).

88. *Id.*

89. Meltzer & Schwartz, *supra* note 28, at 82.

children.<sup>90</sup> However, researchers from New York City's the New School studied a statistically representative sample of 19,000 households to examine the relationship between affordability, general health, and a decision to postpone medical care. Their findings were remarkable because they not only confirmed the relationship between housing affordability and stress, but also revealed the strength of that association. In fact, these researchers conclude that housing affordability is as strong a risk-factor for poor health outcomes due to physical housing defects such as pest infestation, structural defects, leaky plumbing and peeling lead paint.<sup>91</sup>

## 2. Financial Stress

While the evidence suggesting a link between mental health problems and the stress of not having affordable housing may seem obvious, social scientists are just beginning to develop a full understanding. A California Public Health Department teamed with the County Behavioral Health department for a study that interviewed hundreds of public health and behavioral health professionals in the Bay Area. The study found that 94% of these professionals believed the anxiety that arose due to the lack of affordable housing had a direct impact on their clients' health.<sup>92</sup>

Some research shows an association between housing affordability and specific diseases. Dr. Craig Pollack showed, in a study of over 10,000 Pennsylvania residents, that a lack of affordable housing increased the odds of poor self-rated health generally, but also increased the odds of residents with hypertension and arthritis as well.<sup>93</sup> In the same study, the odds that residents experienced cost-related healthcare and medication non-adherence was nearly three times greater among those who found housing unaffordable as compared to those who had access to affordable housing. Another researcher has shown that the impact of unaffordability on homeowners' mental health is less severe than the adverse impact that housing insecurity has on renters.<sup>94</sup>

The relationship between homelessness and illness is cyclical. Homeless individuals and families are more likely to suffer severe and frequent mental and physical illness,<sup>95</sup> and conversely, chronic illness is a known risk factor for

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90. Ingrid Weiss et al., *Safe, Stable Homes Lead to Healthier Children and Families for Baltimore*, CHILDREN'S HEALTHWATCH POLICY ACTION BRIEF (Oct. 2010), [http://www.childrenshealthwatch.org/wp-content/uploads/MDHousing\\_brief\\_October2012.pdf](http://www.childrenshealthwatch.org/wp-content/uploads/MDHousing_brief_October2012.pdf) [<https://perma.cc/Z4Q4-9ES7>].

91. Meltzer & Schwartz, *supra* note 28, at 82.

92. *Improving Housing and Health for All in Alameda County: The Opportunity is Now*, HOUSING BRIEF (Alameda Cty. Pub. Health Dep. and Behav. Health Care Serv.), June 24, 2016, at 3, <http://www.acphd.org/media/425883/housing-brief-june-2016.pdf> [<https://perma.cc/RWJ3-Y7ZD>].

93. Craig E. Pollack et al., *Housing Affordability and Health Among Homeowners and Renters*, 39 AM. J. PREVENTIVE MED. 515, 519–520 (2010).

94. Kate E. Mason et al., *Housing Affordability and Mental Health: Does the Relationship Differ for Renters and Home Purchasers?*, 94 SOC. SCI. MED. 91, 94 (2013).

95. Stephen W. Hwang et al., *A Comprehensive Assessment of Health Care Utilization among*

homelessness.<sup>96</sup> Therefore, while the number of individuals experiencing chronic homelessness has declined in America by 27% between 2010 and 2016, for the estimated 549,928 people who were homeless on a single night in January 2016,<sup>97</sup> the health consequences were severe. The homeless population experiences higher rates of infectious disease (pneumonia, tuberculosis and HIV), chronic medical illness (cardiovascular and obstructive lung disease) and have higher prevalence of psychotic and affective disorders than the general population.<sup>98</sup> As a result, the homeless lack a stable medical provider and therefore burden emergency departments, experience longer lengths of stay once hospitalized, and are admitted as hospital patients more often than the non-homeless.

The adverse impacts that unaffordability in the housing market and health has been well-documented and has grown worse over time, especially for low-income populations.<sup>99</sup> However, the size and demographic characteristics of those burdened by unaffordable housing has changed. More recently, middle-income families are exhibiting the same financial stresses due to housing affordability as low and very low-income families as housing markets become more expensive, and wages fail to keep pace. Unsurprisingly, these families also exhibit a similar decline in self-reported and objectively reported physical and mental health outcomes. Because American housing policy has developed around notions of who is “worthy” of charitable and government interventions to relieve housing cost burdens, state and federal interventions are falling behind an expanding affordability crisis. The “medicalization” lens helps to underscore the problem and offers a way to re-frame the affordability crisis in order to provide new avenues for developing and financing housing policy interventions.

#### IV

##### WHICH COMMUNITIES SHOULD HOUSING POLICY HELP?

Housing policy is seldom just about housing. Nearly every housing program initiated since the 19<sup>th</sup> century has been motivated by concerns that go beyond the provision of decent and affordable housing. For example, the regulatory reforms of the late 19<sup>th</sup> and early 20<sup>th</sup> centuries proscribing minimum standards for light, ventilation, fire safety, and sanitation derived at least as much from a desire to stem the spread of infectious disease and curb antisocial behavior as from a wish to improve living conditions for their own sake.<sup>100</sup>

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*Homeless Adults Under a System of Universal Health Insurance*, 103 AM. J. PUB. HEALTH 294, 294 (2d. Supp. 2013).

96. Margot B. Kushel et al., *Factors Associated with Health Care Utilization of Homeless Persons*, 285 J. AM. MED. ASS’N 200, 203 (2001).

97. U.S. DEPT. OF HOUSING & URB. DEV., OFF. COMMUN. PLANNING & DEV., THE 2016 ANNUAL HOMELESS ASSESSMENT REPORT TO CONGRESS 1 (2016).

98. Bella Schanzer et al., *Homelessness, Health Status, and Health Care Use*, 97 AM. J. PUB. HEALTH 464, 464 (2007).

99. See Matthew Desmond, *Unaffordable America: Poverty, Housing, and Eviction*, INST. RES. ON POVERTY (Mar. 2015), <https://www.irp.wisc.edu/publications/fastfocus/pdfs/FF22-2015.pdf> [<https://perma.cc/6K65-6MY9>].

100. SCHWARTZ, *supra* note 81, at 6.

Alex Schwartz makes the important observation that when governments intervene in private housing markets, they have done so in order to achieve multiple social objectives through housing policy. Schwartz cites seven possible goals for government intervention: expanding supply, promoting racial and economic integration, wealth building, family strengthening, balancing metropolitan growth, and, of course, improving affordability.<sup>101</sup> This section considers these goals as evidence of the degree to which American housing policy has been influenced by a societal interest in the health and well-being of others that motivated the nineteenth century physicians and public health officials described above. The evidence reviewed here shows that American federal housing policy has represented an expression of “conditional” rather than “communal altruism” that has always recognized that housing deficiencies have adverse population health consequences. Yet, housing policy has been primarily driven by the fact that federal funding for housing is a limited resource, for which many interests compete. Thus, instead of focusing on the health impacts of housing, we have made the choice to set housing policy based on the “worthiness” of selected communities. This focus is misplaced, I argue. Instead, a strategy that adopts a public health framework will improve the effectiveness, efficiency, and equity of current approaches to affordable housing policy.

From the beginning, the federal government’s interest in housing interventions has been targeted towards specific populations in order to solve an identifiable social or economic problem, that included (but that was not ever solely) the need to improve public health. Tracing those targeted populations reveals a great deal about the government’s view of its role addressing housing affordability over time.

The nineteenth century concern over squalid conditions that plagued poor laborers and immigrants prompted Congress to authorize two investigations to examine the need for housing assistance in 1892 and 1908. The first appropriation gave \$20,000 to investigate “slums in cities of 200,000 or more population.”<sup>102</sup> Next, Congress appropriated funds to investigate housing conditions of “the poor” and further identified housing health and affordability as the need it sought to address. The 60th Congress’s final report recommended “government loans to build habitable dwellings, condemnation and purchase of slum properties by the government and improvement or replacement of these so that inexpensive and healthful habitations would be available to the poor by rental or purchase at low interest rates.”<sup>103</sup>

Nothing came of this recommendation or the earlier Congressional investigation, that both recognized housing as a social determinant of health and proposed addressing housing problems primarily because of their health

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101. *Id.* at 5.

102. STAFF OF H. COMM. ON FIN. SERV., 108TH CONG., A CHRONOLOGY OF HOUSING LEGISLATION AND SELECTED EXECUTIVE ACTIONS, 1892–2003, at 1 (Comm. Print 2004).

103. *Id.*

impacts.<sup>104</sup> Instead, the federal government was first moved to pass housing laws that addressed poor health because the government needed poor laborers to be healthy enough to work.

During World War I, the country required an efficient labor force, located near the plants that were producing war materials, in order to win the war. Yet the nation faced a housing shortage that “[w]ith each year of the war . . . became more general and more acute, so that by the end of 1918 practically all American cities had failed to replace buildings lost by fire or obsolescence or to provide for the natural increase of population.”<sup>105</sup> In 1918, Congress authorized \$100 million to build homes for shipyard employees,<sup>106</sup> providing these workers housing in “24 localities, including 9,000 homes, 1,100 apartments, 19 dormitories, and 8 hotels.”<sup>107</sup> Later that year, the population targeted was broadened to include all “war workers” when Congress authorized the U.S. Housing Corporation to build and manage over 5,000 single-family homes, most of which were sold to private owners after the war. Although Congress’s housing policy was primarily motivated by the need for laborers, the health of those laborers was clearly what drove Congress’s decision to provide housing.

In its report justifying the need for emergency home construction funds, the United States Housing Corporation explained how “bad housing reduces output” by reciting a long list of ways in which bad housing had an adverse effect on laborers’ health.<sup>108</sup> The list included internal conditions such as poor drainage, structural defects, inadequate plumbing, poor lighting and ventilation, crowded conditions, as well as external conditions such as the proximity to factories that produce chemical gases, dust, or soot. The report cited these housing conditions as factors that led to a wide variety of health hazards including fires, accidents and injuries, weakened immune systems, increased exposure to communicable diseases, and mental health problems described as “cheerlessness, nervous fatigue, and sleeplessness.”<sup>109</sup> The report concluded its discussion of how housing affects health by naming the groups of government workers impacted:

The majority of laborers employed on Government contracts prior to the construction of houses and dormitories by the Government were forced to put up with many of the unwholesome conditions above described, with the consequent impairment of health. The married unskilled workingman lived in the slums of cities, or crowded with other families into houses which had been built for the use of a single family. The unmarried unskilled laborer either lived in a crowded bunk house or shared a room in an already overcrowded house with from two to ten other persons. Skilled married operatives could generally find no accommodations whatsoever for their families, and left them

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104. Still, these early inquiries set the stage for a housing policy that would focus on slum clearance programs. These programs came to be known as “urban renewal.”

105. U.S. DEP’T LAB., BUREAU INDUS. HOUSING & TRANSP., REPORT OF THE UNITED STATES HOUSING CORPORATION: WAR EMERGENCY CONSTRUCTION 1–2 (1920).

106. See Housing Shipyard Employees Act, Pub. L. No. 65-102, 40 Stat. 438 (1918).

107. *Id.*

108. BUREAU INDUS. HOUSING & TRANSP., *supra* note 105, at 2.

109. *Id.*

behind in the cities from which they had come, crowding with other skilled workers, single or married in the homes of private families. As their standards were higher than those of unskilled labor, and as the family bond was strong, this class of labor, which was indispensable to the fulfilment of war contracts, suffered most, and was most discontented and most difficult to retain.<sup>110</sup>

Three months after this account was presented to the Council of National Defense, Congress held hearings featuring testimony from industry leaders such as Illinois Steel Co. and AT&T. In another five months, Congress passed, and the President had signed the bill that appropriated a total of \$100,000,000 to provide housing, local transportation, and other “general community facilities” for industrial war workers.<sup>111</sup> Three months later, the United States joined its Allies in signing the Armistice of Compiègne.

Under the National Housing Act of 1934,<sup>112</sup> Congress established the Federal Housing Administration to facilitate banks making loans for middle-class families seeking to purchase single family homes.<sup>113</sup> These interventions were not directed at improving the health of needy families, but instead were clearly aimed at creating stable living conditions for white, middle, or working class families.<sup>114</sup> The 1934 Act was intended to support the private, commercial real estate industry in its work of providing affordable housing.

#### A. Public Housing

The Great Depression visited hardships that further prompted targeted federal housing interventions. In 1932, the Emergency Relief and Construction Act authorized funds to reconstruct housing for low-income families in New York City and rural Kansas.<sup>115</sup> The Wagner Housing Act of 1937<sup>116</sup> began an era of the federal government’s broader effort to address the need for low-income Americans to have safe, decent, affordable housing nationally. This Act established a federal public housing authority to target slum clearance. Motivated primarily by the need to create jobs to help relieve the severe burdens of the Depression era, the federal government partnered with locally controlled entities through public housing authorities (PHAs) to design and build houses for families hit hard by the Depression. Eligible residents were working class families who were “temporarily poor” and therefore not required to spend more than 30%<sup>117</sup> of their incomes on public housing rent, but who also had incomes that

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110. *Id.* at 3.

111. *Id.* at 12.

112. National Housing Act of 1934, Pub. L. No. 479, 48 Stat. 1246.

113. Charles L. Edson et al., *Affordable Housing – An Intimate History*, in GUIDE TO FEDERAL HOUSING PROGRAMS 3, 4 (Barry G. Jacobs et al. eds., 1986).

114. Kevin Fox Gotham, *Racialization and the State: The Housing Act of 1934 and the Creation of the Federal Housing Administration*, 43 SOC. PERSP. 291, 309 (2000).

115. See Emergency Relief and Construction Act of 1932, Pub. L. No. 72-302, §201, 47 Stat. 709, 711.

116. Wagner Housing Act of 1937, Pub. L. No. 75-412, 50 Stat. 888.

117. Originally, public housing rents were set to cover operating expenses for each project. Congress later capped tenant rents at 25% of income to control increases, and this amount was later increased to

did not exceed six times their rent, so as to protect the private housing market.<sup>118</sup> The goal of the public housing program was to move people out of sub-standard homes into housing that was safe and clean. In fact, the law operated to replace dilapidated neighborhoods called “slums” with new housing units under a provision that could rightly be viewed as a public health measure, as it required one “unsafe and unsanitary” housing unit to be destroyed for each new unit of public housing constructed.<sup>119</sup>

Slum clearance goals gave way to the need to house defense workers during World War II. Under the Lanham Public War Housing Act of 1940<sup>120</sup> Congress required local housing authorities to house defense workers, and later veterans returning from war. Indeed, during World War II, Congress financed housing for defense workers only, expressly excluding the use of those funds for low-income housing.<sup>121</sup> Congress passed the Housing Act of 1949 which authorized construction of 810,000 new public housing units, with the stated goal of “providing a decent home and suitable living environment for all Americans.”<sup>122</sup> However, most agreed this was far short (by 90%) of the estimated housing needs nationwide.<sup>123</sup> Still, these projects were innovations in public-private housing partnerships that targeted families with incomes sufficient to pay operating costs. The Housing Act of 1949 represented a turning point in American housing policy. The piecemeal efforts at slum clearance had failed to eliminate unsanitary living conditions among the poorest Americans. Therefore, housing reformers turned instead to a philosophy that called on government “to enact a massive rental housing program for two-thirds of the American people—not just the lowest third in terms of income (that is, unskilled workers), but also the middle third, which included the working and middle classes.”<sup>124</sup>

Over the next decade, public housing projects were subject to an uneasy alliance among liberal proponents, local, city, and state housing officials across the country seeking to participate in urban renewal, and conservative opponents who lobbied Congress to protect private real estate developers and industry. Increasingly, regulatory controls over construction projects were lifted, and the business of public housing became more “entrepreneurial.”<sup>125</sup> The Housing Act of 1959, for example, created the Section 202 Program which allowed the federal government to make direct loans to non-profit developers building housing for

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30% of household income in 1981.

118. MAGGIE MCCARTY, CONG. RES. SERV., R41654, INTRODUCTION TO PUBLIC HOUSING 2 (2014).

119. *Id.*

120. Lanham Public War Housing Act of 1940, Pub. L. No. 849, 54 Stat. 1125.

121. ALEXANDER VON HOFFMAN, *A Study in Contradictions: The Origins and Legacy of the Housing Act of 1949*, 11 HOUSING POL’Y DEBATE 299, 303 (2000).

122. MCCARTY, *supra* note 118, at 3.

123. VON HOFFMAN, *supra* note 121, at 310.

124. *Id.* at 300.

125. Edson et al., *supra* note 113, at 6.

the elderly.<sup>126</sup> Congress would later adapt the program to also cover affordable housing for handicapped residents under the Cranston-Gonzalez National Affordable Housing Act of 1990.<sup>127</sup> The transition from purely publicly owned housing continued in 1961 when Congress enacted the Section 221(d)(3) Below Market Interest Rate (BMIR) program as part of the Housing Act of 1961,<sup>128</sup> and in 1969 when Congress passed a tax reform act that incentivized development of affordable housing projects with accelerated depreciation, deductible construction interest, and favorable treatment of rollover gains for projects sold to encourage low-income home ownership.<sup>129</sup> Section 515, a similar program to favorably finance private developers of affordable rural housing was enacted in 1962.<sup>130</sup> These programs were largely aimed at providing affordable housing for moderate income families.

The point of these programs was to encourage construction of public housing, but the target populations changed over time. Congress and the Kennedy Administration turned their attention to help families become homeowners whose incomes were not sufficient to qualify for standard mortgages in the private market, but whose incomes were too high to qualify for public housing.<sup>131</sup> Thus, as congressional programs offered generous terms for working class families to leave public housing behind in favor of government subsidized homes, public housing soon became a place for only the poorest families to live. Over the next two decades, public housing buildings deteriorated and fell into disrepair. Public health residents became poorer and sicker. Many factors contributed these changes, but a few stand out.

First, the method for financing public housing has changed. By the late 1960's, the practice of charging rent to cover operating expenses spiraled costs out of control so that in 1969 Senator Edward Brooke introduced an amendment that capped rents at an affordable 30% of family income. This changed the economics—and the financial commitment—of those operating public housing considerably. Regular maintenance ceased and buildings deteriorated. Second, at around the same time, Congress slowed new construction on public housing.<sup>132</sup> The development that continued during the 1960's was performed under a program that allowed private developers to build quickly and to less rigorous

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126. Housing Act of 1959, Pub. L. No. 86-372, §202, 73 Stat. 654, 667.

127. Cranston-Gonzalez National Affordable Housing Act of 1990, Pub. L. No. 101-625, §811, 104 Stat. 4079, 4324.

128. Housing Act of 1961, Pub. L. No. 87-70, 87 Stat. 149. This program was replaced in 1968 by § 236, which provided low-rate (3%) loans to private developers of lower-rent apartments.

129. *See generally* Edson et al., *supra* note 113.

130. SCHWARTZ, *supra* note 81, at 205.

131. *Id.* at 203.

132. *See, e.g.*, Housing and Urban Development Act of 1970, Pub. L. 91-609, 83 Stat. 379. For a continuation of this trend, see Urban-Rural Recovery Act of 1983, Pub. L. No. 98-181, 97 Stat. 1155 (limiting new public housing construction unless it is cheaper than buying existing housing).



structural standards.<sup>133</sup> Third, in 1973, President Nixon imposed a moratorium on all new housing construction which, once ended, shifted focus from building new public housing units to using existing housing in the private market for public housing.<sup>134</sup> Finally, with the physical stock of public housing deteriorating, in 1981, Congress targeted its assistance to the poorest families by restricting public housing eligibility to families with incomes below 50% of the local area median income.<sup>135</sup>

By 1993 the federal government had gradually withdrawn from building or maintaining public housing. Since the mid-1990's, over 250,000 public housing units have been destroyed or withdrawn from the market.<sup>136</sup> Now, the very public housing projects that were intended to relieve unhealthy and unsanitary living conditions have become synonymous with those harmful conditions. Moreover, public housing is once again housing of last resort, reserved for society's poorest individuals with little to offer the government in exchange for a safe, sanitary, affordable home. An argument can be made that the nation's housing policy has succeeded in removing all who could be helped from the public housing rolls, and that should be counted a success. However, this argument fails when we consider the composition of communities that remain in public housing, and the health consequences they suffer.

According to Figure 5, 38% of families in public housing today include children. This means our housing policy ensures that children will bear the worst health impacts from dilapidated housing projects early in life; therefore, those children, their families, and society will bear the costs of housing-related, adverse health impacts over their entire lives. Moreover, the fact that 31% of public housing residents are elderly, and another 16% are disabled adults means that our altruism excludes the neediest populations and is thus conditioned on how "useful" individuals can be to the rest of us. Social psychologists identify this as a form of altruism based on trade relationships and reciprocity.<sup>137</sup> Unlike the notions of communal sharing that characterized the nineteenth century concerns for housing sanitation, or the universal need for housing and job creation during the 1930's, by the 1990's American housing policy appears animated by versions of altruism built on "equality matching" and market relationships in which policy-makers keep track of relative contributions groups of people make, in order to reciprocate with housing assistance.<sup>138</sup>

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133. See Edson et al., *supra* note 113, at 6.

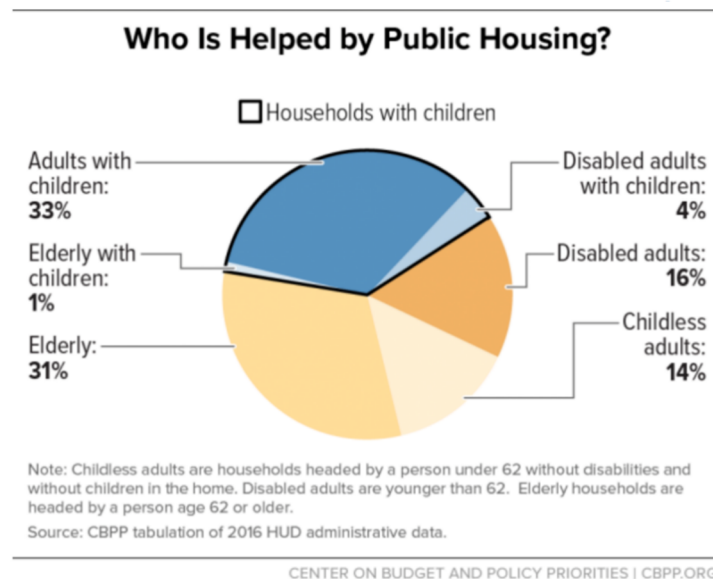
134. MCCARTY, *supra* note 118, at 5.

135. *Id.* at 6.

136. *Public Housing*, POL'Y BASICS (Nov. 15, 2017), <https://www.cbpp.org/research/policy-basics-public-housing> [https://perma.cc/3SH3-PJA5].

137. Peter DeScioli & Siddhi Krishna, *Giving to Whom? Altruism in Different types of Relationships*, 34 J. ECON. PSYCHOL. 218, 219 (2013).

138. *Id.* at 220.

Figure 5: Public Housing Residents' Characteristics, 2016<sup>139</sup>

Public housing residents comprise 23% of all residents receiving federal housing assistance.<sup>140</sup> The vast majority of them are very poor; 64% are categorized as “extremely low income” earning below 30% of the national median; 21% are “very low income” earning 50% of the median; and an additional 9% are “low income” individuals earning 80% of median income.<sup>141</sup> Public housing residents are categorized by age, disability, and whether the household includes children. The largest categories of residents are female-headed households with children (35%) and non-elderly, non-disabled households with children (33%). Nationwide, most of these families are white (52%) and while 20% of these families have occupied public housing for less than a year, a persistent number of households have been in public housing for two to five years or longer.<sup>142</sup> Unsurprisingly, today, public housing residents’ health outcomes are also very poor.

Studies showed repeatedly that public housing residents are among the unhealthiest people in the nation. For example, the HOPE VI Panel Study

139. *Public Housing*, *supra* note 136, at 2.

140. *Who Lives in Federally Assisted Housing?*, HOUSING SPOTLIGHT (Nat’l Low Income Housing Coal., Wash. D.C.), Nov. 2012, at 4 (explaining that approximately 4% of all U.S. households and 12% of all U.S. renter households receive federal housing assistance and approximately 1.1 million people live in public housing).

141. *Resident Characteristics Report*, HOUSING AND URBAN DEVELOPMENT, <https://pic.hud.gov/pic/RCRPublic/rcrmain.asp> [<https://perma.cc/4M5C-P36D>] (last visited Apr. 18, 2018) (click “National” hyperlink, and then go to tab for “Income”).

142. *Id.*

tracked 887 public housing residents from five developments.<sup>143</sup> The study surveyed residents three times—in 2001, 2003, and 2005, asking about their overall health status and specific medical conditions. The study found that to a “shocking” extent, public housing residents consistently suffer worse morbidity and mortality outcomes than the general population. Additionally, their health disparities are exacerbated by a lack of mobility and housing choice options that causes them to remain in the unhealthiest housing conditions imaginable.<sup>144</sup> The population in this study—88% of whom are women, and 90% of whom are black—suffers death rates that exceeded the national average among black women, the category that already suffers one of the highest death rates nationally.<sup>145</sup> In the baseline year of the study, respondents were in “far worse health” than other low-income individuals. In each successive year of the survey, these findings were confirmed. Over 40% of public housing residents in the HOPE VI Panel study self-reported their health was “fair” or “poor.”<sup>146</sup> HOPE VI respondents also suffer chronic illness at a much higher rate than the general population, and twice the rate of other African American women.

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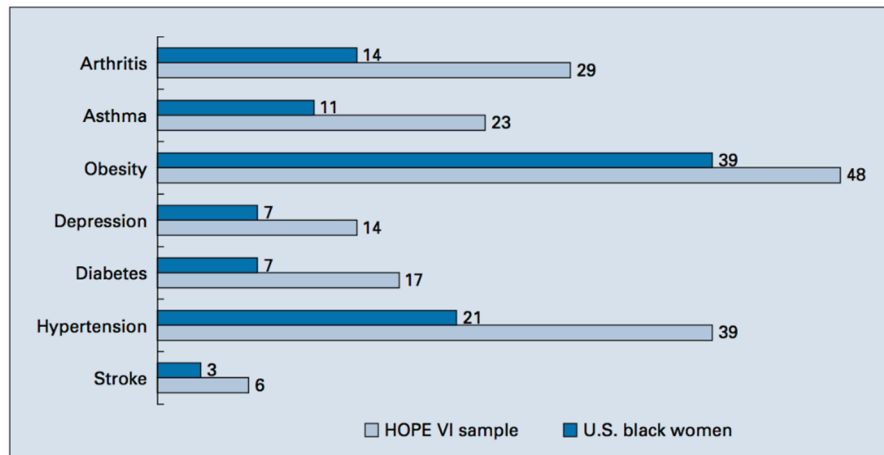
143. Carlos A. Manjarrez et al., *Poor Health: Adding Insult to Injury for HOPE VI Families*, METROPOLITAN HOUSING & COMMUNITIES CTR. (June 2007), <https://www.urban.org/sites/default/files/publication/46306/311489-poor-health-adding-insult-to-injury-for-hope-vi-families.pdf> [<https://perma.cc/E8ZK-HSAV>].

144. Examples include Essex Village Apartments in Henrico County, Virginia where residents complain of living among roaches and rats; investigative journalists report pervasive mold, rotting deck balconies, and crumbling walls, pipes, and plumbing fixtures. See Ashley Monfort, *Essex Village Apartments Called the Worst of the Worst in Henrico*, KCTV5 (Apr. 20, 2017), <http://www.kctv5.com/story/35034351/essex-village-apartments-called-the-worst-of-the-worst-in-henrico> [<https://perma.cc/64C7-SK26>].

145. Manjarrez et al., *supra* note 143, at 4–5.

146. *Id.* at 2.

Figure 6: Chronic Illness Among Hope VI Public Housing Respondents vs. Black Women Nationwide in 2005<sup>147</sup>



Sources: 2005 HOPE VI Panel Study and National Health Interview Survey.

Similarly, a study of Boston public housing residents found higher rates of hypertension, asthma, high cholesterol, diabetes, obesity and depression among these residents.<sup>148</sup> And a study of Moving to Opportunity public housing residents in New York found declining rates of obesity and mental health distress among families that moved away when compared to those who remained in public housing projects.<sup>149</sup> Notably though, the Moving to Opportunity studies have shown that morbidity and mortality rates are not uniformly low among all public housing residents.<sup>150</sup> Yet, it is fair to say that the population that occupies public housing today has come full circle to resemble their nineteenth century counterparts from a public health perspective.

While it is true that people who move to public housing are disproportionately in poor health before they become public housing residents,<sup>151</sup> it is equally true that the state of public housing itself is now a risk factor for poor health outcomes. Much about public housing today bears an unfortunate resemblance to the “wretched tenements” and squalor that the federal government first intervened to relieve with public housing in 1937. The residents largely resemble the lowest income, unskilled, communities that first garnered the attention of nineteenth century housing reformers. Moreover, these residents

147. *Id.* at 3.

148. Eleni C. Digenis-Bury et al., *Use of a Population-based Survey to Describe the Health of Boston Public Housing Residents*, 98 AM. J. PUB. HEALTH 85, 88 (2008).

149. Erin Ruel et al., *Is Public Housing the Cause of Poor Health or a Safety Net for the Unhealthy Poor?*, 87 J. URB. HEALTH 827, 828 (2010).

150. *Cf.* Ludwig et al., *supra* note 49 (a follow-up survey of MTO participants conducted 2008–2010 found varying self-reported and objective health outcomes).

151. *See generally* Ruel et al., *supra* note 149.

similarly occupy the unfortunate position of having nothing more than their poor health and the related unsanitary housing conditions in which they live to call them to the attention of the federal government. But now, it seems, as at the turn of the twentieth century, poverty, poor health, and poor living conditions are insufficient to motivate communal, rather than conditional altruism.

## B. Providing Affordable Housing Through the Private Sector

While public housing was publically owned until the 1990's, the government also attempted to provide affordable housing by subsidizing construction and operation of privately owned homes. The relationship between health and three main approaches—vouchers, mortgage subsidies, and tax credits—bear mention:

### 1. Vouchers

The Housing and Community Development Act of 1974 established a subsidy program called “Section 8” to subsidize rents in new and existing housing owned privately.<sup>152</sup> The program paid private owners the difference between market rents and 30% of tenant incomes. Tenants paid the rest. The part of the program that paid for new construction was called the Section 8 New Construction and Substantial Rehabilitation program. This program proved expensive and was terminated during the Reagan Administration. However, the “Section 8 Existing Housing Program” grew. It established a national voucher program that allowed private landlords to convert housing they already owned into eligible, low-income housing and receive a guaranteed rental income from the government. Today, these vouchers are referred to as “project based” because they benefit tenants living in specific housing units. Within a decade, Section 8 project-based vouchers surpassed public housing and became the leading form of housing assistance in the United States.<sup>153</sup>

In 1983, the voucher program grew to include “freestanding” vouchers that gave low income families the ability to take their vouchers with them to pay subsidized rent, while they contributed 30% of their income to live in qualified housing of their choice.<sup>154</sup> These programs merged in 1993 under the Quality Housing and Work Responsibility Act of 1998 and Congress renamed them as the “Housing Choice Voucher Program” which authorized housing authorities to pay from 90% to 110% of fair market rents, and up to 120% of fair market rents based on market conditions.<sup>155</sup> Similarly, the program set optimal rent levels at 30% of household income, but allowed rent payments up to 40% of income in certain markets.<sup>156</sup> Here, it is worth noting that the 1993 legislation represented a subtle, yet fundamental shift in altruistic considerations that underlie American

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152. Housing and Community Development Act of 1974, 12 U.S.C. § 1706(e) (2012).

153. MCCARTY, *supra* note 118, at 6.

154. SCHWARTZ, *supra* note 81, at 228.

155. *Id.*

156. *Id.* at 230.

approaches to housing policy.

As noted earlier, by the 1960's housing policy reflected altruistic giving that was based on what the recipient contributed to society. The Quality Housing and Work Responsibility Act took a further step beyond communal altruism that tended to characterize early national housing policy. The act reflects altruism based on authoritative relations, relative power, and status.<sup>157</sup> With this law, Congress created hierarchical relationships between state and local housing authorities and the residents they oversee. Moreover, Congress elevated values of independence, self-sufficiency, and work. Consider the U.S. House of Representatives' official summary of the law's purpose: "[T]he bill removes disincentives for residents to work and become self-sufficient, provides rental protection for low-income residents, deregulates the operation of public housing authorities, authorizes the creation of mixed-finance public housing projects, and gives more power and flexibility to local governments and communities to operate housing programs."<sup>158</sup>

By 2009, project-based and free-standing vouchers subsidized more than 2.2 million households and represented the largest federal housing assistance program.<sup>159</sup> However, as with any market-based program, changes in market conditions meant changes in the availability of Section 8 affordable housing. Rental subsidies under Section 8 are contractual and can end when economic conditions force private owners to revert to market-based rents which some families cannot pay.<sup>160</sup> That is the current trend. Recent studies show that as markets tighten, and area vacancy rates decline, voucher holders have more difficulty finding landlords willing to accept vouchers and rent to them.

The communities helped by Section 8 and other voucher housing programs closely resemble the communities helped by public housing programs, with the exception that the latter tend to be more satisfied with their housing. These residents have very low incomes. A high proportion of voucher holders are elderly or disabled. The vast majority (74%) have children and just over half are white.<sup>161</sup> Some have a harder time than others finding affordable housing using vouchers. Large families have more difficulty than smaller families finding affordable housing using vouchers. The elderly and extremely low-income men who are neither elderly, disabled, or living with children experience great difficulty using vouchers to rent affordable housing.<sup>162</sup> Minority families have

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157. See DeScioli & Krishna, *supra* note 137, at 220.

158. 144 CONG. REC. 23,779 (1998).

159. SCHWARTZ, *supra* note 81, at 231. For more information on vouchers, see *Housing Choice Voucher Program*, UNIV. WIS. SCH. MED. & PUB. HEALTH, <http://whatworksforhealth.wisc.edu/program.php?t1=109&t2=126&t3=89&id=342> [https://perma.cc/6ZKE-8XAN] (last visited Feb. 28, 2018).

160. See Ed Gramlich et al., *2013 Advocates' Guide to Housing and Community Development Policy*, NAT'L LOW INCOME HOUSING COAL. 77–78 (2013).

161. SCHWARTZ, *supra* note 81, at 238.

162. *Id.* at 237.

more difficulty using their vouchers to obtain affordable housing than white families.<sup>163</sup>

Although it has been over four decades since Section 8 housing vouchers were introduced, the very low-income families who use these programs have not often been the subject of public health research. Thus, there is little evidence comparing the health of this population to health outcomes among non-voucher holders. This is a serious gap in the literature. Although voucher holders remain economically segregated in ways shown to adversely affect population health outcomes, they are more likely to live in less economically-distressed neighborhoods than their low-income counterparts in public housing.<sup>164</sup> Therefore, their health outcomes may be better. Moreover, families with children who used vouchers to move to neighborhoods with higher educational attainment, also found their children graduated more often, and attended 4-year colleges more often than poor families who remained behind in public housing.<sup>165</sup> This difference may also translate into better health outcomes among voucher holders.

However, to the extent that health gains accrue to voucher-holding families when compared to other low-income households, those gains are much less likely to reach black and Hispanic voucher holders, as compared to the white families who also hold vouchers. First, the evidence to date shows that minority households have more difficulty than white families moving away from racially segregated neighborhoods even with vouchers. Racial segregation has been shown to be a risk factor for poor health outcomes.<sup>166</sup> Second, black and Hispanic voucher families are “underrepresented relative to the availability of affordable housing in low-distress neighborhoods.”<sup>167</sup> Put another way, even with vouchers, minority families have a harder time than white families leaving neighborhoods of concentrated poverty which are highly associated with adverse health outcomes.

## 2. Mortgage Subsidies and Tax Credits

As discussed earlier, beginning in the 1960’s, the federal government sought to provide assistance to families that were too well-off to qualify for public housing, but not wealthy enough to compete for mortgages in the private market.<sup>168</sup> Mortgage subsidy programs took many forms but essentially worked so that the federal government either provided mortgages or paid part of the debt

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163. See Alex Schwartz et al., *Vouchers and Neighborhood Distress: The Unrealized Potential for Families with Housing Choice Vouchers to Reside in Neighborhoods with Low Levels of Distress*, 18 CITYSCAPE: J. POL’Y DEV. & RES. 207, 214–18 (2016).

164. *Id.* at 224.

165. *Id.* at 211.

166. See generally David R. Williams & Selina A. Mohammed, *Racism and Health I: Pathways and Scientific Evidence*, 57 AM. BEHAV. SCI. 1152 (2013).

167. Schwartz et al., *supra* note 163, at 214.

168. See *supra* Part III.A (discussing §§ 221(d)(3), 236, and 515 programs).

service on below-market rate loans to developers in exchange for their agreement to rent to tenants at below-market rental rates. Some of these programs were criticized for helping families that were affluent enough that they really did not need government assistance.<sup>169</sup> Some, such as the program designed to help rural families, combined mortgage subsidies with rent subsidies for very low-income families.<sup>170</sup> Whatever their structures, these programs remain vulnerable to market fluctuations and therefore experience considerable difficulty during inflationary periods or economic recession. They are also temporary programs that end when the mortgage terms to which they are attached expire.

Another way the federal government has subsidized low income housing is through the Low-Income Housing Tax Credit (LIHTC). Created in 1986, this program provides income shelter to developers in order to incentivize them to build low-income housing. Most developers sell the LIHTC to corporate investors and use the cash to help finance construction, but the program's flexibility allows them to determine how much of their developments will be available to low income families. A housing development is eligible for LIHTCs if either a minimum of 20% of the units built are affordable to households earning up to 50% of the metropolitan area's median family income, or if at least 40% of the units are affordable to families earning 60% of the median.<sup>171</sup>

The health impacts of mortgage subsidies and tax credit programs have not been studied. At a minimum, it is reasonable to posit that to the extent that these programs improve access to affordable housing, they are also likely to be associated with improved health outcomes for the reasons discussed in Part II of this article. However, these positive outcomes will also be mitigated to some degree by adverse health impacts that accompany the stress of uncertainty and the instability that is associated with changes in market conditions that reduce or eliminate affordable housing options made available through private sector programs.

## V

### CONCLUSION

Evidence of the association between housing affordability and health outcomes reviewed here supports the view that a medicalized approach to the current crisis has significant advantages. Five benefits have been highlighted in this article. First, a public health framework would encourage rebalancing

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169. See R. ALLEN HAYS, *THE FEDERAL GOVERNMENT AND URBAN HOUSING* 260 (3d ed. 2012).

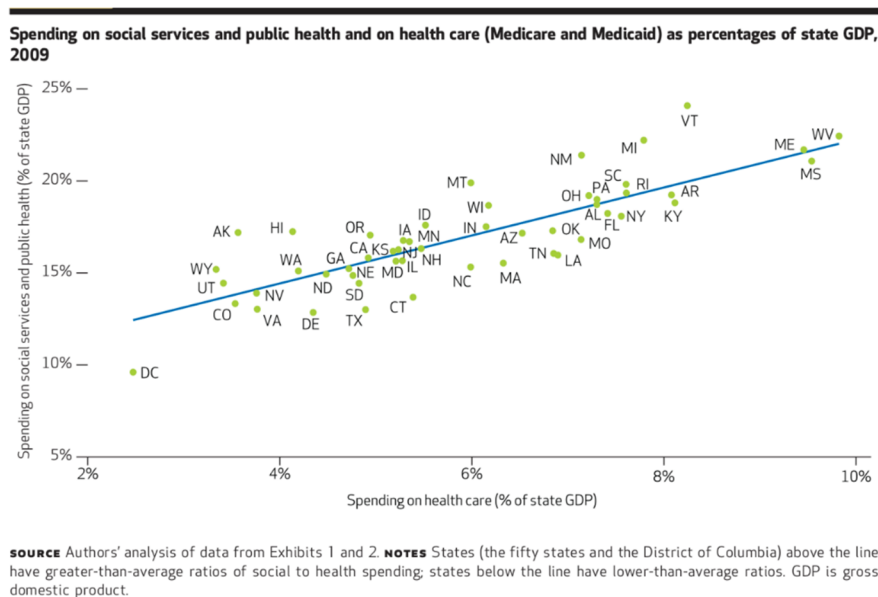
170. See SCHWARTZ, *supra* note 81, at 206–07.

171. See U.S. DEP'T OF HOUSING AND URB. DEV., OFFICE OF POL'Y DEV. AND RES., *DEVELOPMENT AND ANALYSIS OF THE NATIONAL LOW-INCOME HOUSING TAX CREDIT DATABASE* (1996). See also OFFICE OF THE COMPTROLLER OF THE CURRENCY, *LOW-INCOME HOUSING TAX CREDITS: AFFORDABLE HOUSING INVESTMENT OPPORTUNITIES FOR BANKS* (2014); *How Do I know if I'm Eligible for the Low Income Housing Tax Credit Program?*, AFFORDABLE HOUSING ONLINE, <https://affordablehousingonline.com/guide/low-income-housing-tax-credit/am-i-eligible> [<https://perma.cc/DZT5-77MY>] (last visited Mar. 1, 2018).



societal investments to ensure affordable housing for all populations, regardless of income, geography, disability, age, gender, or race. This would encourage abandoning the selective, conditional altruism that has informed policies that identify some but not other populations as worthy recipients of housing assistance. Instead, a public health framework will advance health equity. Second, a public health framework will provide justification for blending currently siloed sources of funding for housing and health programs. This approach is supported by evidence that social interventions are strongly correlated with better health outcomes. For example, researchers have shown that countries that spend a higher proportion of public dollars on health care, relative to social interventions, have demonstrably worse population health outcomes. In other words, a higher ratio of social spending to dollars spent on Medicare, Medicaid, and other health care programs, is associated with better health outcomes.<sup>172</sup> Elizabeth Bradley replicated this positive relationship between social spending and health care spending among the American states. Figure 7 shows that states with the highest ratios had better outcomes in adult obesity, asthma, mental health, lung cancer, heart attack, and type 2 diabetes than states with lower social to medical spending ratios.

Figure 7: State Spending on Social Services, Public Health, and Health Care as Percentages of State GDP, 2009<sup>173</sup>



172. Elizabeth H. Bradley et al., *Health and Social Services Expenditures: Associations with Health Outcomes*, 20 BMJ QUAL. & SAFETY 826, 828 (2011).

173. Elizabeth H. Bradley et al., *Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care*, 35 HEALTH AFF. 760, 766 (2016).

Third, a public health framework would focus housing policy around shared, measureable objectives, to promote interventions that help low, modest, and middle-income families achieve positive health outcomes, rather than policies that cause these groups to compete for scarce housing resources in a zero-sum fashion. Currently, although the U.S. government spent \$190 billion in 2015 to help Americans buy or rent homes, the majority of America's public spending on housing targets higher income households, and pays less attention to low-income families that are at greatest risk for the homelessness, housing instability, and over-crowding problems frequently associated with poor health outcomes.<sup>174</sup> Fourth, a public health approach to housing policy would reorganize housing benefits to achieve a greater good but will also advance better individual outcomes. Finally, and perhaps most importantly, the evidence that children are severely disadvantaged by current U.S. housing policy, leaving them behind in dilapidated public housing, and excluded from affordable neighborhoods when economic circumstances change, argues in favor of a strategy that will not repeatedly impose high health costs on American medical and systems indefinitely. National altruism, markets, and communities are inextricably linked in American housing policy. Policies that focus on the public health impacts of housing affordability will reflect the communal altruism that has historically motivated American housing policy, while also being more effective, efficient, and equitable than current approaches.

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174. Stuart M. Butler et al., *Re-balancing Medical and Social Spending to Promote Health: Increasing State Flexibility to Improve Health Through Housing*, BROOKINGS (Feb. 15, 2017), <https://www.brookings.edu/blog/up-front/2017/02/15/re-balancing-medical-and-social-spending-to-promote-health-increasing-state-flexibility-to-improve-health-through-housing/> [https://perma.cc/3JQS-CKYN].